ILLINOIS DEPARTMENT OF Healthcare and Family Services

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PROVIDER BULLETIN
Update H200-05-01

DATE: September 2, 2005

TO: Participating Hospitals: Chief Executive Officers, Chief Financial Officers, and Patient Accounts Managers

RE: COST OUTLIER PAYMENT CALCULATION REVISION

This bulletin notifies hospitals of a change to the cost outlier payment calculation for admissions occurring on and after July 1, 2005. This change affects hospitals reimbursed by DRG and per diem reimbursement methodologies and is a result of an amendment to 89 Illinois Administrative Code Section 152.

For DRG-reimbursed hospital services with admissions on and after July 1, 2005, the Specific Fixed Loss Threshold used in the cost outlier payment calculation will be multiplied by 1.40. The DRG outlier payment calculation is shown in Appendix H-22f, page 4 in the Handbook for Hospitals.

For per diem-reimbursed hospital services with admissions on and after July 1, 2005, a factor of 0.20 will be used in the outlier payment calculation. The outlier payment calculation for per diem-reimbursed hospitals is shown in Appendix H-22f, pages 4a and 4b.

This bulletin and the replacement handbook pages may be obtained from the department's Web site at: <http://www.hfs.illinois.gov/releases/>. The revisions in the replacement pages are identified by an "=" to the left of the affected text. Paper copies of the revised pages may be obtained by written request. To ensure delivery, you must specify a physical street address when requesting a paper copy.

You may submit your written request to the address below, or fax or e-mail it as noted:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114
Fax Number: (217) 557-8800 / E-Mail Address: PPU@idpa.state.il.us

As you can see, the name of the Department of Public Aid (DPA) has changed to Healthcare and Family Services (HFS). You will see the new name on forms, letters and the Internet. Until existing form supplies are exhausted, we will continue to use materials bearing the former DPA name and logo. Either version of documents should be considered official regardless of the name they bear.

Only our name has changed. HFS's programs, staff, office locations, mailing addresses and phone numbers remain the same as DPA's. We believe our new name more clearly reflects our mission of service to the State of Illinois including providing access to health care for over two million Illinoisans. We deeply appreciate your participation in our programs and we hope this change poses no inconvenience for you.

Providers wishing to receive e-mail notification, when new provider information has been posted by the department, may register at the following HFS Web site:

http://www.hfs.illinois.gov/provrel

Instructions for updating the Handbook for Hospitals:

Remove appendix page H-22f (4) dated December 2001 and replace with the updated page (4) dated August 2005.

Remove appendix pages H-22f (4a) and (4b) dated December 2001 and replace with the updated pages (4a) and (4b) dated August 2005.

Length-of-stay Outlier
Admissions 07/01/95 and After

[1] DRG code (from claim): _____
If the DRG code is within the range of 424-432, then **STOP**. The claim is not subject to reimbursement for length-of-stay outliers.

[2] Length-of-stay (from claim, FL7) _____

[3] DRG outlier cut-off threshold (OCT) (from Table B) _____

[4] Outlier days (line [2] - line [3]) _____
If the result in [4] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for length-of-stay outliers. Go to line [10] and enter zero (0).

[5] DRG federal portion (from Table A, item 6) times
DRG weight (from Page 1, line 5) _____

[6] Geometric mean length-of-stay (GLOS) (from Table B) _____

[7] DRG base price per diem (line [5] divided by [6]) _____

[8] Marginal cost factor: 0.47

[9] Multiply (line [7] x line [8]) _____

[10] Day outlier payment (line [4] x line [9]) _____

Carry the final figure from line [10] over to Page 1 line [9] of the DRG Payment Calculation Worksheet.

= Cost Outlier for DRG-Reimbursed Hospitals
Admissions 12/03/01 Through 06/30/05
And
Admissions 07/01/05 and After

[1] DRG code (from paid claim): _____

[2] Total charges (from claim, FL 47) _____

[3] Noncovered charges (from claim, FL 48) _____

[4] Net charges (line [2] - line [3]) _____

[5] IME factor (from Table A, item 18) _____

[6] IME adjusted charges (line [4] divided by line [5]) _____

[7] Cost to charge ratio (from Table A, item 3) _____

[8] Net covered cost (line [6] x line [7]) _____

[9] Federal rate (from Table A, item 6) _____

[10] DRG relative weighting factor (from Page 1, line 5) _____

[11] National DRG rate (line [9] x line [10]) _____

[12] = Specific fixed loss threshold (Table A, item 17) **x1.22**
admissions 12/03/01 through 06/30/05
OR _____
= Specific fixed loss threshold (Table A, item 17) **x 1.40**
for admissions 07/01/05 and after

[13] Cost outlier threshold (line [11] plus line [12]) _____

[14] Gross outlier cost (line [8] - line [13]) _____
If the result in [14] is less than or equal to zero, then **STOP**.
The claim is not subject to reimbursement for cost outliers.
Go to line 16 and enter zero (0).

[15] Marginal cost factor (effective 1/1/95) 0.80

[16] Cost outlier adjustment (line [14] x line [15]) _____

Carry the final figure from line [16] over to Page 1 line [10] of the DRG Payment Calculation Worksheet.

August 2005

OUTLIER ADJUSTMENT CALCULATION FOR PER DIEM PRICED CLAIMS

For a disproportionate share provider to qualify for an outlier, the patient must be under age six. For a non-disproportionate share provider, the patient must be under age one.

Provider information needed:
*****daily per diem rate
*****daily disproportionate share rate
*****daily MHVA rate
*daily MPA rate
outlier standard deviation amount (in effect on admission date)
outlier cost-to-charge ratio (in effect on admission date)

Claim information needed:
total covered charges
total covered days

*****If the date of service crosses a rate period where there is a rate change, you will have to do steps 5 through 10 twice (one calculation for each rate period) and then add them together.

[1] Outlier standard deviation $_____

[2] Total covered charges $_____

Compare total covered charges to the outlier standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3] Outlier cost-to-charge ratio _____

[4] Multiply line 2 times line 3 $_____

[5] Per diem rate $_____

[6] Disproportionate share rate $_____

[7] MHVA rate $_____

[8] MPA rate $_____

[9] Total of lines 5, 6, 7, and 8 $_____

[10] Number of covered days _____

[11] Multiply line 9 times line 10 $_____

[12] Line 4 total minus line 11 total $_____

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.

= **For admissions prior to December 3, 2001:**
If step 12 is greater than zero, then take step 12 total
X .25 (factor .25 is used for all hospitals) Outlier Amount Due $_____

= **For admissions between December 3, 2001 and June 30, 2005:**
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals) Outlier Amount Due $_____

= **For admissions on or after July 1, 2005:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $_____

EXAMPLE

Provider information:		**Claim information:**	
***daily per diem rate	$ 1,219.11	total covered charges	$152,564.09
***daily disproportionate share rate	$ 60.60	total covered days	45
***daily MHVA rate	$ 87.38		
*daily MPA rate	$ 52.40		
outlier standard deviation amount	$52,682.40		
outlier cost-to-charge ratio	.50		

[1]	Outlier standard deviation		$ 52,682.40
[2]	Total covered charges		$ 152,564.09

Compare total covered charges to the standard deviation. If total covered charges are less than the outlier standard deviation, then **stop**. The claim is not eligible for outlier consideration. If total covered charges are greater than the standard deviation, proceed to step 3.

[3]	Outlier cost-to-charge ratio		.50
[4]	Multiply line 2 times line 3		$ 76,282.05
[5]	Per diem rate	$ 1,219.11	
[6]	Disproportionate share rate	$ 60.60	
[7]	MHVA rate	$ 87.38	
[8]	MPA rate	$ 52.40	
[9]	Total of lines 5, 6, 7, and 8	$ 1,419.49	
[10]	Number of covered days	45	
[11]	Multiply line 9 times line 10		$ 63,877.05
[12]	Line 4 total minus line 11 total		$ 12,405.00

[13] If step 12 total is zero or less, **stop**. The claim is not eligible for an outlier.

= **For admissions prior to December 3, 2001:**
If step 12 is greater than zero, then take step 12 total
X .25 (factor .25 is used for all hospitals): Outlier Amount Due $ 3,101.25

= **For admissions between December 3, 2001 and June 30, 2005:**
If step 12 is greater than zero, then take step 12 total
X .22 (factor .22 is used for all hospitals) Outlier Amount Due $ 2,729.10

= **For admissions on or after July 1, 2005:**
If step 12 is greater than zero, then take step 12 total
X .20 (factor .20 is used for all hospitals) Outlier Amount Due $ 2,481.00